Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALTERNATIVE PSYCHOLOGICAL SERVICES
RETHA ROSS LPC
216 E EXPRESSWAY 83 #6 #F
PHARR TX 78577

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Carrier's Austin Representative Box
Box Number 29

Respondent Name
CITY OF EDINBURG

MFDR Date Received
April 20, 2011

MFDR Tracking Number
M4-11-2858-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as listed on the Table of Disputed Services: "This was preauthorized for treatment"

Amount in Dispute: $12,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The medical bills made the basis of this Medical Fee Dispute were sent back to the bill audit vendor for an additional review along with the information provided by the Requestor. Carrier is issuing additional payments as per the attached EOBs."

Response Submitted by: Pappas & Suchma PC; PO Box 66655; Austin TX 78766

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 12-19, 2010 untimely filed	97799-CP	$4000.00 untimely filed	$0.00
April 20-27, 2010	97799-CP	$3200.00	$0.00
May 12-20, 2010	97799-CP	$4800.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. The requestor was contacted on June 1, 2012 to obtain a current status of this medical fee dispute. The requestor stated that $8000.00 had been received and that the remainder of the disputed amount is still due.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Reconsideration explanation of benefits (EOB) dated May 9, 2011.

- W1 – workers compensation state fee schedule.
- RC OB – payment is 80 percent of the MAR for a CARF-accredited program. Documentation of CARF-accreditation for the program must be provided.
- T250 – reviewed per clients instructions.

Issues

1. Did the requestor timely file for medical dispute resolution per 28 Texas Administrative Code §133.307?
2. Is the requestor eligible for additional reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c) (1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of service in dispute are April 12 to May 20, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on April 20, 2011. Therefore dates of service April 12 to 19, 2010 are untimely filed and will not be reviewed. The remaining disputed dates of service April 20, 2010 to May 20, 2010 are eligible for MDR review.

2. Respondent's position summary states "carrier is issuing additional payments as per the attached EOBs." The EOB notes a payment of $7200.00 for dates of service April 12 to 27, 2010 and $4800.00 for dates of service May 12 to 20, 2010. Reimbursement for a non CARF accredited facility is reimbursed at 80 % of $125.00 per hour according to 28 Texas Administrative Code §134.204(h) (1) (B). The requestor billed eight hours per day times 10 days. The maximum allowable reimbursement (MAR) is calculated as follows:
    - April 20, 22, 26-27, 2009: $125.00/hr x 80% = $100.00 x 8 hrs/day = $800.00 x 4 days = $3200.00 minus insurance carrier payment of $3200.00 = $0.00 additional payment due.
    - May 12-14, 17, 19-20, 2009: $125.00/hr x 80% = $100.00 x 8 hrs/day = $800.00 x 6 days = $4800.00 minus insurance carrier payment of $4800.00 = $0.00 additional payment due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

Authorized Signature

		September , 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.